IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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December 29, 2009

Max Long
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

Provider #131318

Dear Mr. Long:

On **December 22, 2009**, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004451

Allegation #1: Patients who presented to the Critical Access Hospital's (CAH) Emergency Department (ED) were not seen by a physician in a timely manner.

Findings: An unannounced visit was made at the CAH on 12/21/09. Eleven medical records, Performance Improvement documents, and policies were reviewed. Staff were interviewed.

The CAH's Emergency Room Admission policy, dated 12/17/02, stated that if the physician did not come to the ED to assess the patient, a medical screening would be completed by a person designated by the medical staff. The policy did not state how soon an MSE was to be completed. The CAH's Medical Screening Examination (MSE) policy, revised on 9/08, only stated who could perform an MSE and what the MSE included. The policy did not specify when the MSE needed to be completed. Additionally, the CAH's Bi-laws, under Article 3 Categories of Membership, only stated that physicians needed to live within 20 minutes of the hospital. The Bi-laws did not address when ED medical staff needed to be in the ED assessing patients presenting with emergent medical needs.

The Chief Nursing Officer (CNO) was interviewed on 12/21/09 starting at 10:47 AM.

She stated that the CAH did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE.

The Chief of Medicine/ED Medical Director was interviewed on 12/21/09 starting at 3:00 PM. She stated that the hospital did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. However, she stated that the expectation was the ED physicians would see patients within 20 minutes of their arrival at the CAH's ED.

However, review of patient charts included 4 patients who arrived at the ED via ambulance with Cardio Vascular Accident (CVA) symptoms. The patients were not assessed by the physician with in the 20 minute timeframe as stated by the Chief of Medicine/ED Medical Director during the interview on 12/21/09 starting at 3:00 PM. Therefore, the allegation was substantiated. A deficiency was cited at 42 CFR 485.618, Emergency Services, 42 CFR 485.618 (a), Availability, and 42 CFR 485.635 (A)(3)(ii)), Patient Care Policies, for failure of the CAH to provide emergency care services to meet the needs of patients.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: CAH ED staff were rude.

Findings: Eleven medical records, Performance Improvement documents, and policies were reviewed. Staff were interviewed.

The CAH's ED Patient Satisfaction Survey Report, dated from November 2008 to October 2009, was reviewed. The Nursing Staff Courteous and Friendly section of the report documented the following results:

- Completely Dissatisfied: April 2009 = 4%, May 2009 = 3%.

- Somewhat Dissatisfied: November 2008 = 6%, January 2009 = 15%, April 2009 = 4%, May 2009 = 3%, June 2009 = 5%.

The Director of Quality Management was interviewed on 12/21/09 at 10:40 AM. She stated all employees are given a yearly in-service on costumer service. She stated if she received a complaint about an individual, she would follow up with that individual in accordance with the CAH's Complaint and Problem Identification Resolution policy.

The CAH's Complaint and Problem Identification Resolution policy, dated 2002, stated that after receiving a complaint, a report of findings and action taken must be completed and given to the Director of Quality Management within seven days. However, the policy was not implemented as follows:

One patient record documented a patient who was admitted to the CAH ED on 8/25/09 for treatment of a migraine headache. A Process Improvement/Resolution Report, dated 8/27/09, stated the patient complained to the Director of Quality Management. The report stated the patient said the ED nurse was a "jerk to me." The Process Improvement/Resolution Report did not include a report on findings and action taken.

The Director of Quality Management was interviewed on 12/21/09 at 10:40 AM. She stated that she did talk to the nurse about the incident. She stated that the nurse had a history of being "black and white" and felt that the patient was drug seeking. She stated that the nurse was a bit short with the patient and was counseled. However, the Director of Quality Management stated that she did not write a report of findings and actions taken with this complaint.

The CAH failed to ensure that all patient complaints include a report of the findings and actions taken in order to ensure the PI program included all quality indicators, including patient complaints and reported satisfaction.

The CAH failed to ensure the PI program had analyzed all patient complaints. Therefore, the allegation was substantiated. A deficiency was cited at 42 CFR 485.618 (b), Quality Assurance, for failure of the CAH ensure that all patient complaints include a report on the findings and action taken.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: The CAH did not provide Registered Nurse (RN) oversight.

Findings: Eleven medical records, Performance Improvement documents, and policies were reviewed. Staff were interviewed.

The CAH's Position Description for a Certified Paramedic, dated 2009, stated the paramedic provided professional emergency care under the supervision of an RN/Charge Nurse, according to established standards and consulted with and kept the supervisor informed of activities, needs and problems. However, the CAH's Certified Paramedic job description did not state how the RN was to supervise the Certified Paramedic or how the supervision was to be documented.

The job description did not state how the RN would provide supervision or how that supervision would be documented.

The CAH's Position Description for Licensed Practical Nurse, dated 2009, stated the LPN provided professional emergency care under the supervision of an RN/Charge Nurse, according to established standards and consulted with and kept supervisor informed of activities, needs and problems. The job description was in accordance with the Rules of the Idaho Board of Nursing, IDAPA code 23.01.01. 460.02 (a), which states the LPN contributes to the assessment of health status by collecting, reporting and recording objective and subjective data and IDAPA code 23.01.01.460 which states the LPN functions in a dependent role. However, the CAH's LPN job description did not state how the RN was to supervise the LPN or how the supervision was to be documented.

The CAH's Emergency Room Nursing and Physicians policy, dated 3/01, stated the emergency room was to be staffed twenty-four hours a day by a licensed nurse (RN or LPN) and that an RN, preferably trained in advanced cardiac life support, was to be available twenty-four hours a day to supervise nursing activities in the emergency room. The policy was in accordance with the Rules of the Idaho Board of Nursing, IDAPA code 23.01.01.401, which states the RN, in addition to providing hands-on nursing care, works and serves in a broad range of capacities including delegation of duties and that the RN is accountable and responsible for implementation of planned and prescribed nursing care (IDAPA code 23.01.01.401.02 (e)). However, the policy did not include information regarding how the RN was to supervise the staff working under their license or how the supervision was to be documented.

A review of patient charts documented a lack of RN supervision for 4 patients receiving care in the ED from LPNs and paramedics. Examples include, but are not limited to the following:

One patient record documented a patient who was brought to the CAH's ED on 12/16/09 via EMS. A nursing note dated 12/16/09 at 11:30 AM, written by a paramedic, documented that the patient arrived at the CAH by EMS at 11:30 AM. The note stated the patient presented with CVA-like symptoms such as difficulty talking and the inability to follow commands. The note stated the patient's wife reported the symptoms started on 12/15/09 but the patient had not wanted paramedics called at that time. The note further stated the patient was placed on the cardiac monitor and was given oxygen. The patient's record contained the following nursing notes, as documented by the paramedic:

- 12/16/09 at 11:37 AM: The paramedic checked the patient's blood sugar.

- 12/16/09 at 11:49 AM: The paramedic called the ED physician on duty at that time. He documented that he had received laboratory test orders from the physician's office nurse and an order for a CT. The note also stated that the physician would come to see the patient.

- 12/16/09 at 11:54 AM: The paramedic started an IV in the patient's right forearm.

- 12/16/09 at 12:08 PM: The patient was undergoing a CT and that the family was very anxious for the physician to evaluate the patient.

- 12/16/09 at 12:20 PM: The patient's family had signed the patient out Against Medical Advice (AMA) because the physician was not there. However, the patient did not leave AMA.

- 12/16/09 at 12:21 PM: The physician was seeing the patient at that time.

- 12/16/09 at 12:35 PM: The paramedic started an IV in the patient's left arm.

- 12/16/09 at 12:47 PM: The patient was given Labetalol (a blood pressure medication) 5 mg IV followed by a 10 ML saline flush.

- 12/16/09 at 1:05 PM: The paramedic gave report to a Lifeflight RN who was transporting the patient to a hospital for continued care.

The patient's record contained no documented evidence that the CAH's ED RN supervised the paramedic or the patient's care. This was confirmed by the ED RN who was on shift during the patient's admission and stay at the CAH's ED on 12/21/09 at 2:45 PM.

A second patient record documented a patient who was brought to the CAH's ED on 12/11/09 via EMS. The patient's record contained the following nursing notes, as documented by the LPN:

- 12/11/09 at 7:15 PM: The patient had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time the physician arrived was not completed.

- 12/11/09 at 7:34 PM: A report was made by telephone to the physician at 7:34 PM, and orders were received for laboratory tests and a CT.

- 12/11/09 at 8:08 PM: The physician was seeing the patient.

- 12/11/09 from 8:18 PM to 8:35 PM: An RN administered intravenous medication to the patient but no assessment or other care by the RN was documented. The patient's record contained no documented evidence that the CAH's ED RN supervised the LPN or the patient's care.

Two other records reviewed did not include documentation that the RN had supervised the patients' care in the ED.

On 12/21/09 starting at 11:35 AM, the CAH's CNO was interviewed. She stated that an RN was scheduled in the ED 24/7. She stated that the ED RN was also the CAH's Medical Surgical Charge RN during their shift. This was confirmed with review of 11/09 and 12/09 staffing records.

An RN ED/Medical Surgical Charge nurse was interviewed on 12/21/09 starting at 2:45 PM. She stated that the ED paramedics and other staff were very confident in assessing and caring for patients. She stated that she did oversee their care provided to patients, but did not document that oversight in patients' records.

The CAH failed to ensure an RN had supervise and evaluated the nursing care for patients. Therefore, the allegation was substantiated. A deficiency was cited at 42 CFR 485.635 (d)(2), Nursing Supervision, for failure of the CAH ensure that care was provided and/or supervised by an RN.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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January 22, 2010

Certified Mail Number: 7007 0710 0002 7979 0666

Max Long
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

RE: Walter Knox Memorial Hospital, provider #131318

Dear Mr. Long:

We have received your Allegation of Compliance (AOC) for the survey completed at Walter Knox Memorial Hospital on December 22, 2009. After careful review, it has been determined that additional information is needed before your plan can be accepted. Please add the information, described below to your AOC for each tag noted, and return it to our office by **February 4, 2010**.

The Allegation of Compliance for Walter Knox Memorial Hospital did not contain the following elements:

201

- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable AOC for the deficiency cited;
- The plan must include the title of the person responsible for implementing the acceptable AOC.

274

- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable AOC for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the AOC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the AOC.

296

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable AOC for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the AOC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable AOC.

Thank you in advance for your cooperation. If you have any questions, please do not hesitate to contact this office at (208) 334-6626.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING _____	C 12/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your CAH. The investigation was conducted by Patrick Hendrickson, RN, HFS. Acronyms used in this report include: AMA = Against Medical Advice CAH = Critical Access Hospital CNO = Chief Nursing Officer CT = Computed Tomography, a radiological test utilizing multiple x-rays CVA = Cardio Vascular Accident ED = Emergency Department EKG = Electrocardiograph EMS = Emergency Medical Service IV = Intravenous LPN = Licensed Practical Nurse MG = Milligrams MSE = Medical Screening Evaluation PA = Physician's Assistant PI = Performance Improvement RN = Registered Nurse	C 000	RECEIVED FEB 0 1 2010 FACILITY STANDARDS	
C 200	485.618 EMERGENCY SERVICES The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients. This CONDITION is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to provide emergency care services to meet the needs of patients. This resulted in a delay in the assessment of patients' medical needs. The findings include: 1. Refer to C201 as it relates to the failure of the CAH to ensure physicians were on-site and	C 200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Max Long — TITLE: CEO — (X6) DATE: 1-28-10 1-21-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 200	Continued From page 1 assessing patients' medical needs within 30 minutes. 2. Refer to C274 as it relates to the facility's failure to ensure policies and procedures for emergency medical services were developed and/or implemented to meet all of emergency service requirements. 3. Refer to C296 as it relates to the failure of the facility to ensure RNs' had supervised and evaluated the nursing care provider by dependent staff (LPNs and paramedics) in their deliverance of patient emergency care. The cumulative effect of these negative facility practices impeded the ability of the facility to provide emergency services in a timely fashion and had the potential to result in negative patient outcomes.	C 200		
C 201	485.618(a) AVAILABILITY Emergency services are available on a 24-hours a day basis. This STANDARD is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to ensure physicians were on-site and assessing patients' medical needs within 30 minutes. This directly impacted 4 of 6 patients (Patients #1, #4, #9, and #10) who arrived via ambulance and whose records were reviewed and had the potential to impact all patients arriving at the ED. This resulted in patients with CVA symptoms not receiving a timely assessment by the physician and had the potential to cause negative patient outcomes due to a delay in the stabilization and treatment of	C 201	C 201 A Medical Screening Examination will be completed within 30 minutes of arrival on each person presenting to the hospital for Emergency care. See Policy in Addendum: A-Emergency Room Admission B-Staffing Emergency Room C-Medical Screening Examination and Medical Staff Rules currently require physicians to comply with EMTALA regulations. They will be revised to require physician or mid-level to see emergent patients within 30 minutes. See Addendum D-Medical Staff Rules page 64 To ensure the process is completed, a Quality Improvement indicator has been developed and tracking will begin effective February 1, 2010. See Addendum E: Trending Sheet	

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C 201	Continued From page 2 patients' emergency medical needs. The findings include: 1. The CNO was interviewed on 12/21/09 starting at 10:47 AM. She stated that the CAH did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. The Chief of Medicine/ED Medical Director was interviewed on 12/21/09 starting at 3:00 PM. She stated that the hospital did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. However, she stated that the expectation was the ED physicians would see patients within 20 minutes of their arrival at the CAH's ED. Review of patient charts included 4 patients who arrived at the ER via ambulance with CVA symptoms. The patients were not assessed by the physician within the 20 minute timeframe as stated by the Chief of Medicine/ED Medical Director during the interview on 12/21/09 starting at 3:00 PM. The patients' records included the following: a. Patient #1 was a 75 year-old-male who was brought to the CAH's ED on 12/16/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #1 at 11:26 AM. However, a nursing note, dated 12/16/09 at 11:30 AM, written by a paramedic, documented that Patient #1 arrived at the CAH by EMS at 11:30 AM. The note stated that Patient #1 presented with CVA like symptoms such as difficulty talking and inability to follow commands. The note stated that Patient #1's wife reported the	C 201	Amendment to C 201 As of January 18, 2010, all Emergency Room Nursing Department staff have been advised individually of the policy changes that include the timeframes. The responsible position is the Chief Nursing Officer.	

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C 201	Continued From page 3 symptoms started on 12/15/09 but Patient #1 had not wanted paramedics called at that time. The note further stated that Patient #1 was placed on the cardiac monitor and was given oxygen. A nursing note, written by the paramedic, dated 12/16/09 at 11:49 AM, stated he called the ED physician on duty at that time. He documented that he had received laboratory test orders from the physician's office nurse and an order for a CT. The note also stated that the physician would come to see Patient #1. A second nursing note, written by the paramedic, dated 12/16/09 at 12:08 PM, stated that Patient #1 was undergoing a CT and that the family was very anxious for the physician to evaluate Patient #1. A Process Improvement/Resolution report, dated 12/16/09, documented the physician was having lunch and would come in and evaluate Patient #1 when she was finished. A third nursing note, written by the paramedic, dated 12/16/09 at 12:20 PM, stated Patient #1's family had signed Patient #1 out AMA because the physician was not there. However, Patient #1 did not leave AMA. The CAH's ED flow sheet contained the physician's initial assessment. The flow sheet stated the physician arrived at the ED at 12:15 PM, 45 minutes after the patient had arrived at the ED. However, a nursing note, written by the paramedic, dated 12/16/09 at 12:21 PM, stated the physician was seeing Patient #1 at that time. Patient #1's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff,	C 201		

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C 201	Continued From page 4 for 51 minutes after the patient had arrived at the ED. The CNO was interviewed on 12/21/09 starting at 10:47 AM. She reviewed Patient #1's record and confirmed that the physician had not completed a physical assessment until 51 minutes after Patient #1 had arrived at the ED. Patient #1's ED physician was interviewed on 12/21/09 starting at 3:00 PM. She stated she had received a report from her office nurse that a patient was at the ED. She stated that the nurse reported that Patient #1 had stroke-like symptoms for more then a day. The physician stated her nurse told her that it would probably be too late to use any "clot busters" (medications that would dissolve a blood clot). The ED physician stated that she gave diagnostic orders and was waiting for diagnostic testing to be completed before she saw Patient #1. The CAH failed to ensure Patient #1's ED physician assessed his medical needs within 30 minutes of arrival. b. Patient #4 was a 72 year-old-male who was brought to the CAH's ED on 10/13/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #4 at 1:27 PM. A nursing note, dated 10/13/09 at 1:30 PM, written by a paramedic, documented that Patient #4 arrived by EMS with a complaint of new onset CVA like symptoms. It stated that Patient #4's wife reported the symptoms started around 1:00 PM, when he suddenly could not speak and was confused. The paramedic documented Patient #4 had right sided weakness and difficulties communicating. The note stated that Patient #4	C 201		

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C 201	Continued From page 5 was placed on the cardiac monitor and was given oxygen. The next paramedic note, dated 10/13/09 at 1:40 PM, stated he (the paramedic) called the ED physician on duty at that time. On 10/13/09 at 2:00 PM, the paramedic documented that he received a phone call back from the PA and obtained orders. An ED flow sheet, dated 10/13/09 at 2:00 PM, documented the orders were a CT of the head, laboratory tests and an EKG. Patient #4's Physician's Orders and Progress Note, dated 10/13/09 but not timed, written by the ED physician, documented that "I soon as I was notify [sic] I came here immediately to assess the PT (patient)." The physician noted Patient #4 had a new hemianopia (medical description of a type of partial blindness where vision is missing in the inner half of both the right and left visual field) with mental statues changes. The physician stated Patient #4 was intermittently confused. The physician documented that he (the physician) was going to hold thrombolytics (blood thinning medications used to reduce the risk of forming blood clots) because of the patient's neurological changes and wanted a full neurological evaluation at a secondary hospital where the physician was transferring Patient #4. A nursing note, dated 10/13/09 at 2:10 PM, documented by the paramedic, stated the physician was assessing Patient #4 at that time. Patient #4 was transferred to a secondary hospital at 3:15 PM for continued treatment. Patient #4's record did not document that a physical assessment or MSE had been	C 201		

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C 201	Continued From page 6 completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff, for 40 minutes after the patient arrived at the ED. The CNO was interviewed on 12/21/09 starting at 3:50 PM. She confirmed that Patient #4's ED physician did not physically see the patient within the expected 20 minutes which was the Chief of Medicine/ED Medical Director's expectations. The CAH failed to ensure Patient #4's ED physician assessed his medical needs within 30 minutes of arrival. c. Patient #9 was a 59 year-old-female who was brought to the CAH's ED on 12/11/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #9 at 7:11 PM. However, Patient #9's ED flow sheet, that contained an assessment, written by the LPN on 12/11/09 at 7:15 PM, stated the patient arrived at that time. The ED flow sheet stated that Patient #9 had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time the physician arrived was not completed. A second nursing note, written by the LPN, dated 12/11/09 at 7:34 PM, stated a report was made by telephone to the physician at 7:34 PM, and orders were received for laboratory tests and a CT. The LPN documented the physician saw Patient #9 at 8:08 PM. This was 53 minutes after Patient #9 had arrived at the ED. However, a	C 201		

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C 201	Continued From page 7 note titled "PHYSICIAN'S RECORD-HISTORY-PHYSICAL EXAMINATION," was dated 12/11/09 at 8:00 PM. The physician documented that he had assessed Patient #9 at that time. Patient #9's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff, for 53 minutes after Patient #9 arrived at the ED. The CNO was interviewed on 12/21/09 starting at 3:50 PM. She confirmed that Patient #9's ED physician did not physically see Patient #9 within the expected 20 minutes which was the Chief of Medicine/ED Medical Director's expectations. The CAH failed to ensure Patient #9's ED physician assessed her medical needs within 30 minutes of arrival. d. Patient #10 was a 60 year-old-male who was brought to the CAH's ED on 10/15/09 via EMS. His ED flow sheet, written by the LPN on 10/15/09 at 6:25 PM, stated Patient #9 ambulated into the ER and the chief complaint was "MENTAL STATUS CHANGE." The assessment section of the flowsheet stated Patient #10 was disoriented. A nursing note, written by the LPN on 10/15/09 at 6:30 PM, stated the physician was notified of the patient's arrival at that time. A nursing note, written by the LPN on 10/15/09 at 7:35 PM, stated the physician saw Patient #10 at that time. Patient #10's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel	C 201		

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C 201	Continued From page 8 practitioner, as designated by the medical staff, for 1 hour and 10 minutes after Patient #10 arrived at the ED. The CNO was interviewed on 12/21/09 starting at 3:50 PM. She confirmed that Patient #10's ED physician did not physically see Patient #10 within the expected 20 minutes which was the Chief of Medicine/ED Medical Director's expectations.	C 201		
C 274	485.635(a)(3)(ii) PATIENT CARE POLICIES [The policies include the following:] (ii) policies and procedures for emergency medical services This STANDARD is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to ensure policies and procedures for emergency medical services were sufficiently developed to ensure all emergency staff were directed in ED expectations. This directly impacted 4 of 6 patients (Patients #1, #4, #9, and #10) who arrived via ambulance and whose records were reviewed and had the potential to impact all patients arriving at the ED. Without sufficient policies, the facility would not be able to ensure all ED staff completed initial assessments/MSEs within the time frames established by the Chief of Medicine/ED Medical Director. The findings include: 1. The CAH's Emergency Room Admission policy, dated 12/17/02, stated that if the physician did not come to the ED to assess the patient, a medical screening would be completed by a person designated by the medical staff, which	C 274	C 274 Cited Policies have been revised to include timeframes for Emergency Services and Medical Screening Examinations. See Policy in Addendum: A-Emergency Room Admission B-Staffing Emergency Room C-Medical Screening Examination Also Medical Staff Rules revision as noted in deficiency C 201 D-Medical Staff Bylaws page 64 Amendment to C 274 As noted in C201, as of January 18, 2010, all Nursing Department staff who work in the Emergency Room have been advised of the policy changes and the requirement for the completion of MSE's within the specified timeframes. The same Quality Improvement indicator monitoring completion times for MSE's will be used. See Addendum E: Trending Sheet The responsible position is the Chief Nursing Officer.	

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C 274	Continued From page 9 included RNs and midlevel practitioners (a PA or a Nurse Practitioner). The policy did not state how soon an MSE was to be completed. The CAH's Medical Screening Examination (MSE) policy, revised 9/08, only stated who could perform an MSE and what the MSE included. The policy did not specify when the MSE needed to be completed. Additionally, the CAH's Bi-laws, under Article 3 Categories of Membership, only stated that physicians needed to live within 20 minutes of the hospital. The Bi-laws did not address when ED medical staff needed to be in the ED assessing patients presenting with emergent medical needs. The CAH's Emergency Room Nursing and Physicians policy, dated 3/01, stated "Physician services in the Emergency Room are available twenty-four hours a day." The policy did not include when ED medical staff needed to be in the ED assessing patients presenting with emergent medical needs. The CNO was interviewed on 12/21/09 starting at 10:47 AM. She stated that the CAH did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. A review of patient charts documented varying time frames for how soon patients were seen for an assessment/MSE by qualified ED staff (physician, RN, or midlevel practitioners) after they arrived at the ER. The patients' records documented the following: a. Patient #1 was a 75 year-old-male who was brought to the CAH's ED on 12/16/09 via EMS.	C 274		

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C 274	Continued From page 10 The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #1 at 11:26 AM. However, a nursing note, dated 12/16/09 at 11:30 AM, written by a paramedic, documented that Patient #1 arrived at the CAH by EMS at 11:30 AM. The note stated that Patient #1 presented with CVA-like symptoms such as difficulty talking and inability to follow commands. Subsequent notes documented the paramedic continued to care for Patient #1 until 12:15 PM. Patient #1's CAH's ED flow sheet contained the physician's initial assessment. The flow sheet stated the physician arrived at the ED at 12:15 PM, 45 minutes after Patient #1 had arrived at the ED. However, a nursing note, dated 12/16/09 at 12:21 PM, stated the physician was seeing Patient #1 at that time, 51 minutes after Patient #1 arrived at the ED. Beyond the care that the paramedic provided, Patient #1's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff, for 51 minutes after Patient #1 arrived at the ED. b. Patient #4 was a 72 year-old-male who was brought to the CAH's ED on 10/13/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #4 at 1:27 PM. A nursing note dated 10/13/09 at 1:30 PM, written by a paramedic, documented that Patient #4 arrived by EMS with a complaint of new onset CVA like symptoms. Subsequent notes documented the paramedic continued to care for Patient #4 until 10/13/09 at 2:10 PM, when the paramedic documented the physician was assessing Patient #4 at that time.	C 274		

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C 274	Continued From page 11 Patient #4's record did not document that a physical assessment or MSE had been completed by the physician or an RN or midlevel practitioner, as designated by the medical staff, for 40 minutes after the patient had arrived at the ED. c. Patient #9 was a 59 year-old-female who was brought to the CAH's ED on 12/11/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #9 at 7:11 PM. However, Patient #9's ED flow sheet, written by an LPN on 12/11/09 at 7:15 PM, stated the patient arrived at that time. The note stated that Patient #9 had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time they arrived was not completed. Subsequent notes documented the LPN continued to care for Patient #9 until 8:08 PM, when the LPN documented the physician saw the patient. An additional note, titled "PHYSICIAN'S RECORD-HISTORY-PHYSICAL EXAMINATION," was dated 12/11/09 at 8:00 PM. Patient #9's record did not document that a physical assessment or MSE had been completed by the physician or an RN or midlevel practitioner, as designated by the medical staff, for 45 minutes after the patient had arrived at the ED. d. Patient #10 was a 60 year-old-male who was brought to the CAH's ED on 10/15/09 via EMS.	C 274		

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C 274	Continued From page 12 His ED flow sheet, written by the LPN on 10/15/09 at 6:25 PM, stated the patient ambulated into the ER and the chief complaint was "MENTAL STATUS CHANGE." The assessment stated Patient #10 was disoriented and had a history of bladder cancer. Subsequent notes documented the LPN continued to care for Patient #10 until 7:35 PM when the LPN documented the physician saw the patient at that time. Patient #10's record did not document that a physical assessment or MSE had been completed by the physician or an RN or midlevel practitioner, as designated by the medical staff, for 1 hour and 10 minutes after the patient had arrived at the ED. The Chief of Medicine/ED Medical Director was interviewed on 12/21/09 starting at 3:00 PM. She stated that the hospital did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. However, she stated the expectation was the ED physicians would see patients within 20 minutes of their arrival at the CAH's ED.	C 274		
C 296	485.635(d)(2) NURSING SERVICES A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH. This STANDARD is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to ensure an RN had supervised and evaluated the nursing care for 4	C 296	C 296 Indications for direct supervision of non-RN staff by an RN have been added to the Policy. See Policy in Addendum: B-Staffing Emergency Room F-Standards of Nursing Practice	

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C 296	Continued From page 13 of 11 patients (Patients #1, #4, #9 and #10) who presented to the ED and whose records were reviewed. Failure to ensure an RN supervised the nursing care provided by dependent staff had the potential to delay emergency care services including but not be limited to, the stabilization and treatment of patients' emergency medical needs, resulting in potential negative patient outcomes. The findings include: 1. The CAH's Position Description for a Certified Paramedic, dated 2009, stated the paramedic provided professional emergency care under the supervision of an RN/Charge Nurse, according to established standards and consulted with and kept the supervisor informed of activities, needs and problems. However, the CAH's Certified Paramedic job description did not state how the RN was to supervise the Certified Paramedic or how the supervision was to be documented. The job description did not state how the RN would provide supervision or how that supervision would be documented. The CAH's Position Description for Licensed Practical Nurse, dated 2009, stated the LPN provided professional emergency care under the supervision of an RN/Charge Nurse, according to established standards and consulted with and kept supervisor informed of activities, needs and problems. The job description was in accordance with the Rules of the Idaho Board of Nursing, IDAPA code 23.01.01. 460.02 (a), which states the LPN contributes to the assessment of health status by collecting, reporting and recording objective and subjective data and IDAPA code 23.01.01.460 which states the LPN functions in a dependent role. However, the CAH's LPN job	C 296	Amendment to C 296 The policy included in Addendum A has been further revised to include ER providers as additional persons responsible to directly supervise the care provided by the non-RN staff and is immediately effective. In addition, all ER records are reviewed by an RN for the purpose of assessing chart/documentation completion, appropriateness of nursing care, and accuracy of charges. This has been added to the policy, Addendum F and will be tracked on the Trending Sheet beginning February 1, 2010. The responsible position is the Chief Nursing Officer	

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C 296	Continued From page 14 description did not state how the RN was to supervise the LPN or how the supervision was to be documented. The CAH's Emergency Room Nursing and Physicians policy, dated 3/01, stated the emergency room was to be staffed twenty-four hours a day by a licensed nurse (RN or LPN) and that an RN, preferably trained in advanced cardiac life support, was to be available twenty-four hours a day to supervise nursing activities in the emergency room. The policy was in accordance with the Rules of the Idaho Board of Nursing, IDAPA code 23.01.01.401, which states the RN, in addition to providing hands-on nursing care, works and serves in a broad range of capacities including delegation of duties and that the RN is accountable and responsible for implementation of planned and prescribed nursing care (IDAPA code 23.01.01.401.02 (e)). However, the policy did not include information regarding how the RN was to supervise the staff working under their license or how the supervision was to be documented. A review of patient charts documented a lack of RN supervision for patients receiving care in the ED from LPNs and paramedics as follows: a. Patient #1 was a 75 year-old-male who was brought to the CAH's ED on 12/16/09 via EMS. A nursing note dated 12/16/09 at 11:30 AM, written by a paramedic, documented that Patient #1 arrived at the CAH by EMS at 11:30 AM. The note stated that Patient #1 presented with CVA-like symptoms such as difficulty talking and the inability to follow commands. The note stated that Patient #1's wife reported the symptoms started on 12/15/09 but Patient #1 had not wanted	C 296		

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C 296	Continued From page 15	C 296		

paramedics called at that time. The note further stated that Patient #1 was placed on the cardiac monitor and was given oxygen. Patient #1's record contained the following nursing notes, as documented by the paramedic:

- 12/16/09 at 11:37 AM: The paramedic checked Patient #1's blood sugar.

- 12/16/09 at 11:49 AM: The paramedic called the ED physician on duty at that time. He documented that he had received laboratory test orders from the physician's office nurse and an order for a CT. The note also stated that the physician would come to see Patient #1.

- 12/16/09 at 11:54 AM: The paramedic started an IV in Patient #1's right forearm.

- 12/16/09 at 12:08 PM: Patient #1 was undergoing a CT and that the family was very anxious for the physician to evaluate the patient.

- 12/16/09 at 12:20 PM: Patient #1's family had signed the patient out AMA because the physician was not there. However, Patient #1 did not leave AMA.

- 12/16/09 at 12:21 PM: The physician was seeing Patient #1 at that time.

- 12/16/09 at 12:35 PM: The paramedic started an IV in Patient #1's left arm.

- 12/16/09 at 12:47 PM: Patient #1 was given Labetalol (a blood pressure medication) 5 mg IV followed by a 10 ML saline flush.

- 12/16/09 at 1:05 PM: The paramedic gave

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C 296	Continued From page 16 report to a Lifeflight RN who was transporting Patient #1 to a hospital for continued care. Patient #1's record contained no documented evidence that the CAH's ED RN supervised the paramedic or Patient #1's care. This was confirmed by the ED RN on shift during Patient #1's admission and stay at the CAH's ED on 12/21/09 at 2:45 PM. b. Patient #4 was a 72 year-old-male who was brought to the CAH's ED on 10/13/09 via EMS. Patient #4's record contained the following nursing notes, as documented by the paramedic: - 10/13/09 at 1:30 PM: Patient #4 arrived by EMS with a complaint of new onset CVA-like symptoms. Patient #4's wife reported the symptoms started around 1:00 PM, when he suddenly could not speak and was confused and was placed on the cardiac monitor and given oxygen. - 10/13/09 at 1:40 PM: The paramedic called the ED physician on duty. - 10/13/09 at 2:00 PM,: The paramedic documented that he received a phone call back from the physician's PA and obtained orders. - 10/13/09 at 2:10 PM, The patient was back from radiology and placed back on the monitors and the physician was assessing Patient #4 at that time. - 10/13/09 at 2:15 PM: The paramedic started an IV in Patient #4's left forearm. - 10/13/09 at 2:25 PM: Patient #4's EKG was	C 296		

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C 296	Continued From page 17 completed. - 10/13/09 at 2:30 PM: A urine sample was collected from Patient #4. - 10/13/09 at 2:45 PM: Patient #4 was to be transferred to a hospital and now had good motor movements on his right side. - 10/13/09 at 3:00 PM: Patient #4 was transferred to the helipad for transfer to a helicopter. The paramedic documented that Patient #4 was stable and report and copies of Patient #4's chart were given to the Lifeflight crew. - 10/13/09 at 3:15 PM: The paramedic called the secondary hospital's ED and gave a report. Patient #4's record contained no documented evidence that the CAH's ED RN had supervised the paramedic or Patient #4's care. c. Patient #9 was a 59 year-old-female who was brought to the CAH's ED on 12/11/09 via EMS. Patient #9's record contained the following nursing notes, as documented by the LPN: - 12/11/09 at 7:15 PM: Patient #9 had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time the physician arrived was not completed. - 12/11/09 at 7:34 PM: A report was made by telephone to the physician at 7:34 PM, and orders	C 296		

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C 296	Continued From page 18 were received for laboratory tests and a CT. - 12/11/09 at 8:08 PM: The physician was seeing Patient #9. - 12/11/09 from 8:18 PM to 8:35 PM: An RN administered intravenous medication to Patient #9 but no assessment or other care by the RN was documented. Patient #9's record contained no documented evidence that the CAH's ED RN supervised the LPN or Patient #9's care. d. Patient #10 was a 60 year-old-male who was brought to the CAH's ED on 10/15/09 via EMS. Patient #10's record contained the following nursing notes, as documented by the LPN: - 10/15/09 at 6:25 PM: The patient ambulated into the ER and the chief complaint was "MENTAL STATUS CHANGE." The assessment stated Patient #10 was disoriented. - 10/15/09 at 6:30 PM: The physician was notified of Patient #10's arrival at that time. The only person to assess Patient #10 between his arrival at 6:25 PM and the physician's examination at 7:35 PM, was an LPN as documented in the 10/15/09 nursing notes. - 10/15/09 at 10:10 PM: Patient #10 was transferred to a regional medical center via ambulance. Patient #10's record contained no nursing notes by an RN to indicate the RN supervised the LPN or Patient #10's care. On 12/21/09 starting at 11:35 AM, the CAH's	C 296		

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	131318	A. BUILDING _____ B. WING _____	C 12/22/2009

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C 296	Continued From page 19 CNO was interviewed. She stated that an RN was scheduled in the ED 24/7. She stated that the ED RN was also the CAH's Medical Surgical Charge RN during their shift. This was confirmed with review of 11/09 and 12/09 staffing records. An RN ED/Medical Surgical Charge nurse was interviewed on 12/21/09 starting at 2:45 PM. She stated that the ED paramedics and other staff were very confident in assessing and caring for patients. She stated that she did oversee their care provided to patients, but did not document that oversight in patients' records. The hospital failed to ensure care was provided and/or supervised by an RN.	C 296		
C 336	485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that - This STANDARD is not met as evidenced by: Based on staff interview and review of patient records and PI records, it was determined the CAH failed to ensure the PI program had analyzed all patient complaints for 1 of 2 patients (Patient #11) reviewed, who had filed complaints. This resulted in the potential for the CAH's ability to develop and implement processes to improve patient relations to be impeded. The findings include: 1. The CAH's ED Patient Satisfaction Survey Report, dated from November 2008 to October 2009, was reviewed. The Nursing Staff	C 336		

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C 336	Continued From page 20 Courteous and Friendly section of the report documented the following results: - Completely Dissatisfied: April 2009 = 4%, May 2009 = 3%. - Somewhat Dissatisfied: November 2008 = 6%, January 2009 = 15%, April 2009 = 4%, May 2009 = 3%, June 2009 = 5%. The Director of Quality Management was interviewed on 12/21/09 at 10:40 AM. She stated all employees are given a yearly in-service on costumer service. She stated if she received a complaint about an individual, she would follow up with that individual in accordance with the CAH's Complaint and Problem Identification Resolution policy. The CAH's Complaint and Problem Identification Resolution policy, dated 2002, stated that after receiving a complaint, a report of findings and action taken must be completed and given to the Director of Quality Management within seven days. However, the policy was not implemented as follows: Patient #11 was a 52-year-old female who was admitted to the CAH ED on 8/25/09 for treatment of a migraine headache. A Process Improvement/Resolution Report, dated 8/27/09, stated Patient #11 complained to the Director of Quality Management. The report stated Patient #11 said the ED nurse was a "jerk to me." The Process Improvement/Resolution Report did not include a report on findings and action taken. The Director of Quality Management was interviewed on 12/21/09 at 10:40 AM. She stated	C 336		

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C 336	Continued From page 21 that she did talk to the nurse about the incident. She stated that the nurse had a history of being "black and white" and felt that Patient #11 was drug seeking. She stated that the nurse was a bit short with Patient #11 and was counseled. However, the Director of Quality Management stated that she did not write a report of findings and actions taken with this complaint. The CAH failed to ensure that all patient complaints include a report of the findings and actions taken in order to ensure the PI program included all quality indicators, including patient complaints and reported satisfaction.	C 336		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 336	Continued From page 20 Courteous and Friendly section of the report documented the following results: - Completely Dissatisfied: April 2009 = 4%, May 2009 = 3%. - Somewhat Dissatisfied: November 2008 = 6%, January 2009 = 15%, April 2009 = 4%, May 2009 = 3%, June 2009 = 5%. The Director of Quality Management was interviewed on 12/21/09 at 10:40 AM. She stated all employees are given a yearly in-service on costumer service. She stated if she received a complaint about an individual, she would follow up with that individual in accordance with the CAH's Complaint and Problem Identification Resolution policy. The CAH's Complaint and Problem Identification Resolution policy, dated 2002, stated that after receiving a complaint, a report of findings and action taken must be completed and given to the Director of Quality Management within seven days. However, the policy was not implemented as follows: Patient #11 was a 52-year-old female who was admitted to the CAH ED on 8/25/09 for treatment of a migraine headache. A Process Improvement/Resolution Report, dated 8/27/09, stated Patient #11 complained to the Director of Quality Management. The report stated Patient #11 said the ED nurse was a "jerk to me." The Process Improvement/Resolution Report did not include a report on findings and action taken. The CNO was interviewed on 12/21/09 at 10:40 AM. She stated that she did talk to the nurse	C 336	C 336: Unfortunately there was a miscommunication on this statement because that is not the Quality Management Director's normal process, nor is that in accordance with our policy. And I apologize if anything said misled the reviewer to believe this is our process. Employees are given a yearly customer in-service, this part of the statement is correct. Additionally, they are provided with routine customer service emails that include customer service motivational quotes that have been submitted by fellow employees. We have a customer service team which is lead by our HR Director that meets several times a year in an effort to keep our focus on delivering stellar customer service. However, if there is a complaint about an individual, that information is provided to that individual's Department Manager on our PI forms (blue sheets) who in turn is responsible for the findings and actions related to counseling/education, disciplinary steps, etc. with their staff. The Department Head then returns the form to the QM Director with written/verbal responses, from which the QM Director prepares a report that is reviewed and discussed at our monthly QI Committee meeting. That same report is available for review and discussion at Medical Staff and our Board of Directors. As was the case with patient #11. There is a similar process in our HR/Community Relations Department for negative comments noted on returned patient satisfaction surveys. This does not mean that the QM Director never discusses an incident with specific staff involved. Sometimes staff will request additional information or just feel the need to further explain in addition to what they have already discussed with their supervisor. Or QM Director may have the need for additional information from staff. But the responsibility for staff follow up does fall to the individual Department Managers, which is per our policy. In the future, WKMH will be more diligent in obtaining a completed response from the Department Managers requiring comprehensive documentation of findings and actions. Our existing PI form has been modified to enforce this. As noted on this revised form, if the QM Director has not received a response back within 7 working days from the Department Manager, the CEO will be notified. A copy of the revised PI form has been attached along with the two monthly QI reports where the incident with patient #11 was reported and a copy of our policy regarding the handling of patient complaints. 1-21-10 Gay Johnson, RN QM Director	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 336	Continued From page 21 about the incident. She stated that the nurse had a history of being "black and white" and felt that Patient #11 was drug seeking. She stated that the nurse was a bit short with Patient #11 and was counseled. During this interview the Director of Quality Management stated that she did not write a report of findings and actions taken with this complaint. The CAH failed to ensure that all patient complaints include a report of the findings and actions taken in order to ensure the PI program included all quality indicators, including patient complaints and reported satisfaction.	C 336		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint survey of your CAH. The investigation was conducted by Patrick Hendrickson, RN, HFS.	B 000		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C336 as it relates to the failure of the CAH to ensure the PI program had analyzed all patient complaints.	BB124	RECEIVED FEB 01 2010 FACILITY STANDARDS	
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88) 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to,	BB297		

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BB297	Continued From page 1 the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and (10-14-88) c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88) g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs, equipment, and supplies; and (10-14-88) i. Policy and supporting procedures involving toxicology; and (10-14-88)	BB297		

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BB297	Continued From page 2 j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88) k. Policy involving instructions relative to disclosure of patient information; and (10-14-88) l. A policy for integration of the emergency room into a disaster plan. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C274 as it relates to the facility's failure to ensure policies and procedures for emergency medical services were developed and/or implemented to meet all of emergency service requirements.	BB297		
BB298	16.03.14.370.02 Staffing 02. Staffing. There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: (10-14-88) a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed. (10-14-88) b. A qualified registered nurse shall be on duty in the facility and available to the emergency room at all times. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C201 as it relates to the failure of the CAH to ensure physicians were on-site and assessing patients' medical needs within 30 minutes. 2. Refer to C296 as it relates to the failure of the	BB298		

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BB298	Continued From page 3 facility to ensure RN had supervised and evaluated the nursing care provided by dependent staff (LPNs and paramedics) in their deliverance of patient emergency care.	BB298		

FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0659

December 29, 2009

Max Long
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

RE: Walter Knox Memorial Hospital, provider #131318

Dear Mr. Long:

Based on the complaint survey completed at Walter Knox Memorial Hospital on December 22, 2009 by our staff, we have determined that Walter Knox Memorial Hospital is out of compliance with the Medicare Hospital Conditions of Participation on Emergency Services (42 CFR 485.618). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this condition to be unmet substantially limit the capacity of Walter Knox Memorial Hospital to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **February 5, 2010. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than January 28, 2010.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures
ec: Kate Mitchell, CMS Region X Office

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C 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your CAH. The investigation was conducted by Patrick Hendrickson, RN, HFS. Acronyms used in this report include: AMA = Against Medical Advice CAH = Critical Access Hospital CNO = Chief Nursing Officer CT = Computed Tomography, a radiological test utilizing multiple x-rays CVA = Cardio Vascular Accident ED = Emergency Department EKG = Electrocardiograph EMS = Emergency Medical Service IV = Intravenous LPN = Licensed Practical Nurse MG = Milligrams MSE = Medical Screening Evaluation PA = Physician's Assistant PI = Performance Improvement RN = Registered Nurse	C 000	RECEIVED JAN 25 2010 FACILITY STANDARDS	
C 200	485.618 EMERGENCY SERVICES The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients. This CONDITION is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to provide emergency care services to meet the needs of patients. This resulted in a delay in the assessment of patients' medical needs. The findings include: 1. Refer to C201 as it relates to the failure of the CAH to ensure physicians were on-site and	C 200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Max Long | CEO | 1-21-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 200	Continued From page 1 assessing patients' medical needs within 30 minutes. 2. Refer to C274 as it relates to the facility's failure to ensure policies and procedures for emergency medical services were developed and/or implemented to meet all of emergency service requirements. 3. Refer to C296 as it relates to the failure of the facility to ensure RNs' had supervised and evaluated the nursing care provider by dependent staff (LPNs and paramedics) in their deliverance of patient emergency care. The cumulative effect of these negative facility practices impeded the ability of the facility to provide emergency services in a timely fashion and had the potential to result in negative patient outcomes.	C 200		
C 201	485.618(a) AVAILABILITY Emergency services are available on a 24-hours a day basis. This STANDARD is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to ensure physicians were on-site and assessing patients' medical needs within 30 minutes. This directly impacted 4 of 6 patients (Patients #1, #4, #9, and #10) who arrived via ambulance and whose records were reviewed and had the potential to impact all patients arriving at the ED. This resulted in patients with CVA symptoms not receiving a timely assessment by the physician and had the potential to cause negative patient outcomes due to a delay in the stabilization and treatment of	C 201	C 201 A Medical Screening Examination will be completed within 30 minutes of arrival on each person presenting to the hospital for Emergency care. See Policy in Addendum: A-Emergency Room Admission B-Staffing Emergency Room C-Medical Screening Examination and Medical Staff Rules currently require physicians to comply with EMTALA regulations. They will be revised to require physician or mid-level to see emergent patients within 30 minutes. See Addendum D-Medical Staff Rules page 64 To ensure the process is completed, a Quality Improvement indicator has been developed and tracking will begin effective February 1, 2010. See Addendum E: Trending Sheet	

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C 201	Continued From page 2 patients' emergency medical needs. The findings include: 1. The CNO was interviewed on 12/21/09 starting at 10:47 AM. She stated that the CAH did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. The Chief of Medicine/ED Medical Director was interviewed on 12/21/09 starting at 3:00 PM. She stated that the hospital did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. However, she stated that the expectation was the ED physicians would see patients within 20 minutes of their arrival at the CAH's ED. Review of patient charts included 4 patients who arrived at the ER via ambulance with CVA symptoms. The patients were not assessed by the physician within the 20 minute timeframe as stated by the Chief of Medicine/ED Medical Director during the interview on 12/21/09 starting at 3:00 PM. The patients' records included the following: a. Patient #1 was a 75 year-old-male who was brought to the CAH's ED on 12/16/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #1 at 11:26 AM. However, a nursing note, dated 12/16/09 at 11:30 AM, written by a paramedic, documented that Patient #1 arrived at the CAH by EMS at 11:30 AM. The note stated that Patient #1 presented with CVA like symptoms such as difficulty talking and inability to follow commands. The note stated that Patient #1's wife reported the	C 201		

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	131318	A. BUILDING _____ B. WING _____	C 12/22/2009

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C 201	Continued From page 3 symptoms started on 12/15/09 but Patient #1 had not wanted paramedics called at that time. The note further stated that Patient #1 was placed on the cardiac monitor and was given oxygen. A nursing note, written by the paramedic, dated 12/16/09 at 11:49 AM, stated he called the ED physician on duty at that time. He documented that he had received laboratory test orders from the physician's office nurse and an order for a CT. The note also stated that the physician would come to see Patient #1. A second nursing note, written by the paramedic, dated 12/16/09 at 12:08 PM, stated that Patient #1 was undergoing a CT and that the family was very anxious for the physician to evaluate Patient #1. A Process Improvement/Resolution report, dated 12/16/09, documented the physician was having lunch and would come in and evaluate Patient #1 when she was finished. A third nursing note, written by the paramedic, dated 12/16/09 at 12:20 PM, stated Patient #1's family had signed Patient #1 out AMA because the physician was not there. However, Patient #1 did not leave AMA. The CAH's ED flow sheet contained the physician's initial assessment. The flow sheet stated the physician arrived at the ED at 12:15 PM, 45 minutes after the patient had arrived at the ED. However, a nursing note, written by the paramedic, dated 12/16/09 at 12:21 PM, stated the physician was seeing Patient #1 at that time. Patient #1's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff,	C 201		

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C 201	Continued From page 4 for 51 minutes after the patient had arrived at the ED. The CNO was interviewed on 12/21/09 starting at 10:47 AM. She reviewed Patient #1's record and confirmed that the physician had not completed a physical assessment until 51 minutes after Patient #1 had arrived at the ED. Patient #1's ED physician was interviewed on 12/21/09 starting at 3:00 PM. She stated she had received a report from her office nurse that a patient was at the ED. She stated that the nurse reported that Patient #1 had stroke-like symptoms for more then a day. The physician stated her nurse told her that it would probably be too late to use any "clot busters" (medications that would dissolve a blood clot). The ED physician stated that she gave diagnostic orders and was waiting for diagnostic testing to be completed before she saw Patient #1. The CAH failed to ensure Patient #1's ED physician assessed his medical needs within 30 minutes of arrival. b. Patient #4 was a 72 year-old-male who was brought to the CAH's ED on 10/13/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #4 at 1:27 PM. A nursing note, dated 10/13/09 at 1:30 PM, written by a paramedic, documented that Patient #4 arrived by EMS with a complaint of new onset CVA like symptoms. It stated that Patient #4's wife reported the symptoms started around 1:00 PM, when he suddenly could not speak and was confused. The paramedic documented Patient #4 had right sided weakness and difficulties communicating. The note stated that Patient #4	C 201		

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C 201	Continued From page 5 was placed on the cardiac monitor and was given oxygen. The next paramedic note, dated 10/13/09 at 1:40 PM, stated he (the paramedic) called the ED physician on duty at that time. On 10/13/09 at 2:00 PM, the paramedic documented that he received a phone call back from the PA and obtained orders. An ED flow sheet, dated 10/13/09 at 2:00 PM, documented the orders were a CT of the head, laboratory tests and an EKG. Patient #4's Physician's Orders and Progress Note, dated 10/13/09 but not timed, written by the ED physician, documented that "I soon as I was notify [sic] I came here immediately to assess the PT (patient)." The physician noted Patient #4 had a new hemianopia (medical description of a type of partial blindness where vision is missing in the inner half of both the right and left visual field) with mental statues changes. The physician stated Patient #4 was intermittently confused. The physician documented that he (the physician) was going to hold thrombolytics (blood thinning medications used to reduce the risk of forming blood clots) because of the patient's neurological changes and wanted a full neurological evaluation at a secondary hospital where the physician was transferring Patient #4. A nursing note, dated 10/13/09 at 2:10 PM, documented by the paramedic, stated the physician was assessing Patient #4 at that time. Patient #4 was transferred to a secondary hospital at 3:15 PM for continued treatment. Patient #4's record did not document that a physical assessment or MSE had been	C 201		

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C 201	Continued From page 6 completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff, for 40 minutes after the patient arrived at the ED. The CNO was interviewed on 12/21/09 starting at 3:50 PM. She confirmed that Patient #4's ED physician did not physically see the patient within the expected 20 minutes which was the Chief of Medicine/ED Medical Director's expectations. The CAH failed to ensure Patient #4's ED physician assessed his medical needs within 30 minutes of arrival. c. Patient #9 was a 59 year-old-female who was brought to the CAH's ED on 12/11/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #9 at 7:11 PM. However, Patient #9's ED flow sheet, that contained an assessment, written by the LPN on 12/11/09 at 7:15 PM, stated the patient arrived at that time. The ED flow sheet stated that Patient #9 had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time the physician arrived was not completed. A second nursing note, written by the LPN, dated 12/11/09 at 7:34 PM, stated a report was made by telephone to the physician at 7:34 PM, and orders were received for laboratory tests and a CT. The LPN documented the physician saw Patient #9 at 8:08 PM. This was 53 minutes after Patient #9 had arrived at the ED. However, a	C 201		

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C 201	Continued From page 7 note titled "PHYSICIAN'S RECORD-HISTORY-PHYSICAL EXAMINATION," was dated 12/11/09 at 8:00 PM. The physician documented that he had assessed Patient #9 at that time. Patient #9's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff, for 53 minutes after Patient #9 arrived at the ED. The CNO was interviewed on 12/21/09 starting at 3:50 PM. She confirmed that Patient #9's ED physician did not physically see Patient #9 within the expected 20 minutes which was the Chief of Medicine/ED Medical Director's expectations. The CAH failed to ensure Patient #9's ED physician assessed her medical needs within 30 minutes of arrival. d. Patient #10 was a 60 year-old-male who was brought to the CAH's ED on 10/15/09 via EMS. His ED flow sheet, written by the LPN on 10/15/09 at 6:25 PM, stated Patient #9 ambulated into the ER and the chief complaint was "MENTAL STATUS CHANGE." The assessment section of the flowsheet stated Patient #10 was disoriented. A nursing note, written by the LPN on 10/15/09 at 6:30 PM, stated the physician was notified of the patient's arrival at that time. A nursing note, written by the LPN on 10/15/09 at 7:35 PM, stated the physician saw Patient #10 at that time. Patient #10's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel	C 201		

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C 201	Continued From page 8 practitioner, as designated by the medical staff, for 1 hour and 10 minutes after Patient #10 arrived at the ED. The CNO was interviewed on 12/21/09 starting at 3:50 PM. She confirmed that Patient #10's ED physician did not physically see Patient #10 within the expected 20 minutes which was the Chief of Medicine/ED Medical Director's expectations.	C 201		
C 274	485.635(a)(3)(ii) PATIENT CARE POLICIES [The policies include the following:] (ii) policies and procedures for emergency medical services This STANDARD is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to ensure policies and procedures for emergency medical services were sufficiently developed to ensure all emergency staff were directed in ED expectations. This directly impacted 4 of 6 patients (Patients #1, #4, #9, and #10) who arrived via ambulance and whose records were reviewed and had the potential to impact all patients arriving at the ED. Without sufficient policies, the facility would not be able to ensure all ED staff completed initial assessments/MSEs within the time frames established by the Chief of Medicine/ED Medical Director. The findings include: 1. The CAH's Emergency Room Admission policy, dated 12/17/02, stated that if the physician did not come to the ED to assess the patient, a medical screening would be completed by a person designated by the medical staff, which	C 274	C 274 Cited Policies have been revised to include timeframes for Emergency Services and Medical Screening Examinations. See Policy in Addendum: A-Emergency Room Admission B-Staffing Emergency Room C-Medical Screening Examination Also Medical Staff Rules revision as noted in deficiency C 201 D-Medical Staff Bylaws page 64	

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C 274	Continued From page 9 included RNs and midlevel practitioners (a PA or a Nurse Practitioner). The policy did not state how soon an MSE was to be completed. The CAH's Medical Screening Examination (MSE) policy, revised 9/08, only stated who could perform an MSE and what the MSE included. The policy did not specify when the MSE needed to be completed. Additionally, the CAH's Bi-laws, under Article 3 Categories of Membership, only stated that physicians needed to live within 20 minutes of the hospital. The Bi-laws did not address when ED medical staff needed to be in the ED assessing patients presenting with emergent medical needs. The CAH's Emergency Room Nursing and Physicians policy, dated 3/01, stated "Physician services in the Emergency Room are available twenty-four hours a day." The policy did not include when ED medical staff needed to be in the ED assessing patients presenting with emergent medical needs. The CNO was interviewed on 12/21/09 starting at 10:47 AM. She stated that the CAH did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. A review of patient charts documented varying time frames for how soon patients were seen for an assessment/MSE by qualified ED staff (physician, RN, or midlevel practitioners) after they arrived at the ER. The patients' records documented the following: a. Patient #1 was a 75 year-old-male who was brought to the CAH's ED on 12/16/09 via EMS.	C 274		

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C 274	Continued From page 10 The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #1 at 11:26 AM. However, a nursing note, dated 12/16/09 at 11:30 AM, written by a paramedic, documented that Patient #1 arrived at the CAH by EMS at 11:30 AM. The note stated that Patient #1 presented with CVA-like symptoms such as difficulty talking and inability to follow commands. Subsequent notes documented the paramedic continued to care for Patient #1 until 12:15 PM. Patient #1's CAH's ED flow sheet contained the physician's initial assessment. The flow sheet stated the physician arrived at the ED at 12:15 PM, 45 minutes after Patient #1 had arrived at the ED. However, a nursing note, dated 12/16/09 at 12:21 PM, stated the physician was seeing Patient #1 at that time, 51 minutes after Patient #1 arrived at the ED. Beyond the care that the paramedic provided, Patient #1's record did not document that a physical assessment or MSE had been completed by the physician, an RN, or midlevel practitioner, as designated by the medical staff, for 51 minutes after Patient #1 arrived at the ED. b. Patient #4 was a 72 year-old-male who was brought to the CAH's ED on 10/13/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #4 at 1:27 PM. A nursing note dated 10/13/09 at 1:30 PM, written by a paramedic, documented that Patient #4 arrived by EMS with a complaint of new onset CVA like symptoms. Subsequent notes documented the paramedic continued to care for Patient #4 until 10/13/09 at 2:10 PM, when the paramedic documented the physician was assessing Patient #4 at that time.	C 274		

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C 274	Continued From page 11 Patient #4's record did not document that a physical assessment or MSE had been completed by the physician or an RN or midlevel practitioner, as designated by the medical staff, for 40 minutes after the patient had arrived at the ED. c. Patient #9 was a 59 year-old-female who was brought to the CAH's ED on 12/11/09 via EMS. The EMS run sheet stated the ambulance arrived at the CAH's ED with Patient #9 at 7:11 PM. However, Patient #9's ED flow sheet, written by an LPN on 12/11/09 at 7:15 PM, stated the patient arrived at that time. The note stated that Patient #9 had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time they arrived was not completed. Subsequent notes documented the LPN continued to care for Patient #9 until 8:08 PM, when the LPN documented the physician saw the patient. An additional note, titled "PHYSICIAN'S RECORD-HISTORY-PHYSICAL EXAMINATION," was dated 12/11/09 at 8:00 PM. Patient #9's record did not document that a physical assessment or MSE had been completed by the physician or an RN or midlevel practitioner, as designated by the medical staff, for 45 minutes after the patient had arrived at the ED. d. Patient #10 was a 60 year-old-male who was brought to the CAH's ED on 10/15/09 via EMS.	C 274		

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C 274	Continued From page 12 His ED flow sheet, written by the LPN on 10/15/09 at 6:25 PM, stated the patient ambulated into the ER and the chief complaint was "MENTAL STATUS CHANGE." The assessment stated Patient #10 was disoriented and had a history of bladder cancer. Subsequent notes documented the LPN continued to care for Patient #10 until 7:35 PM when the LPN documented the physician saw the patient at that time. Patient #10's record did not document that a physical assessment or MSE had been completed by the physician or an RN or midlevel practitioner, as designated by the medical staff, for 1 hour and 10 minutes after the patient had arrived at the ED. The Chief of Medicine/ED Medical Director was interviewed on 12/21/09 starting at 3:00 PM. She stated that the hospital did not have an ED policy that would direct physicians as to when they needed to be at patients' bedsides to perform a physical assessment or an MSE. However, she stated the expectation was the ED physicians would see patients within 20 minutes of their arrival at the CAH's ED.	C 274		
C 296	485.635(d)(2) NURSING SERVICES A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH. This STANDARD is not met as evidenced by: Based on interviews of CAH staff and review of medical records and CAH policies, it was determined the CAH failed to ensure an RN had supervised and evaluated the nursing care for 4	C 296	C 296 Indications for direct supervision of non-RN staff by an RN have been added to the Policy. See Policy in Addendum: B-Staffing Emergency Room F-Standards of Nursing Practice	

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C 296	Continued From page 13 of 11 patients (Patients #1, #4, #9 and #10) who presented to the ED and whose records were reviewed. Failure to ensure an RN supervised the nursing care provided by dependent staff had the potential to delay emergency care services including but not be limited to, the stabilization and treatment of patients' emergency medical needs, resulting in potential negative patient outcomes. The findings include: 1. The CAH's Position Description for a Certified Paramedic, dated 2009, stated the paramedic provided professional emergency care under the supervision of an RN/Charge Nurse, according to established standards and consulted with and kept the supervisor informed of activities, needs and problems. However, the CAH's Certified Paramedic job description did not state how the RN was to supervise the Certified Paramedic or how the supervision was to be documented. The job description did not state how the RN would provide supervision or how that supervision would be documented. The CAH's Position Description for Licensed Practical Nurse, dated 2009, stated the LPN provided professional emergency care under the supervision of an RN/Charge Nurse, according to established standards and consulted with and kept supervisor informed of activities, needs and problems. The job description was in accordance with the Rules of the Idaho Board of Nursing, IDAPA code 23.01.01. 460.02 (a), which states the LPN contributes to the assessment of health status by collecting, reporting and recording objective and subjective data and IDAPA code 23.01.01.460 which states the LPN functions in a dependent role. However, the CAH's LPN job	C 296		

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C 296	Continued From page 14 description did not state how the RN was to supervise the LPN or how the supervision was to be documented. The CAH's Emergency Room Nursing and Physicians policy, dated 3/01, stated the emergency room was to be staffed twenty-four hours a day by a licensed nurse (RN or LPN) and that an RN, preferably trained in advanced cardiac life support, was to be available twenty-four hours a day to supervise nursing activities in the emergency room. The policy was in accordance with the Rules of the Idaho Board of Nursing, IDAPA code 23.01.01.401, which states the RN, in addition to providing hands-on nursing care, works and serves in a broad range of capacities including delegation of duties and that the RN is accountable and responsible for implementation of planned and prescribed nursing care (IDAPA code 23.01.01.401.02 (e)). However, the policy did not include information regarding how the RN was to supervise the staff working under their license or how the supervision was to be documented. A review of patient charts documented a lack of RN supervision for patients receiving care in the ED from LPNs and paramedics as follows: a. Patient #1 was a 75 year-old-male who was brought to the CAH's ED on 12/16/09 via EMS. A nursing note dated 12/16/09 at 11:30 AM, written by a paramedic, documented that Patient #1 arrived at the CAH by EMS at 11:30 AM. The note stated that Patient #1 presented with CVA-like symptoms such as difficulty talking and the inability to follow commands. The note stated that Patient #1's wife reported the symptoms started on 12/15/09 but Patient #1 had not wanted	C 296		

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	131318	A. BUILDING _____ B. WING _____	C 12/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

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C 296	Continued From page 15	C 296		

paramedics called at that time. The note further stated that Patient #1 was placed on the cardiac monitor and was given oxygen. Patient #1's record contained the following nursing notes, as documented by the paramedic:

- 12/16/09 at 11:37 AM: The paramedic checked Patient #1's blood sugar.

- 12/16/09 at 11:49 AM: The paramedic called the ED physician on duty at that time. He documented that he had received laboratory test orders from the physician's office nurse and an order for a CT. The note also stated that the physician would come to see Patient #1.

- 12/16/09 at 11:54 AM: The paramedic started an IV in Patient #1's right forearm.

- 12/16/09 at 12:08 PM: Patient #1 was undergoing a CT and that the family was very anxious for the physician to evaluate the patient.

- 12/16/09 at 12:20 PM: Patient #1's family had signed the patient out AMA because the physician was not there. However, Patient #1 did not leave AMA.

- 12/16/09 at 12:21 PM: The physician was seeing Patient #1 at that time.

- 12/16/09 at 12:35 PM: The paramedic started an IV in Patient #1's left arm.

- 12/16/09 at 12:47 PM: Patient #1 was given Labetalol (a blood pressure medication) 5 mg IV followed by a 10 ML saline flush.

- 12/16/09 at 1:05 PM: The paramedic gave

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C 296	Continued From page 16 report to a Lifeflight RN who was transporting Patient #1 to a hospital for continued care. Patient #1's record contained no documented evidence that the CAH's ED RN supervised the paramedic or Patient #1's care. This was confirmed by the ED RN on shift during Patient #1's admission and stay at the CAH's ED on 12/21/09 at 2:45 PM. b. Patient #4 was a 72 year-old-male who was brought to the CAH's ED on 10/13/09 via EMS. Patient #4's record contained the following nursing notes, as documented by the paramedic: - 10/13/09 at 1:30 PM: Patient #4 arrived by EMS with a complaint of new onset CVA-like symptoms. Patient #4's wife reported the symptoms started around 1:00 PM, when he suddenly could not speak and was confused and was placed on the cardiac monitor and given oxygen. - 10/13/09 at 1:40 PM: The paramedic called the ED physician on duty. - 10/13/09 at 2:00 PM,: The paramedic documented that he received a phone call back from the physician's PA and obtained orders. - 10/13/09 at 2:10 PM, The patient was back from radiology and placed back on the monitors and the physician was assessing Patient #4 at that time. - 10/13/09 at 2:15 PM: The paramedic started an IV in Patient #4's left forearm. - 10/13/09 at 2:25 PM: Patient #4's EKG was	C 296		

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C 296	Continued From page 17 completed. - 10/13/09 at 2:30 PM: A urine sample was collected from Patient #4. - 10/13/09 at 2:45 PM: Patient #4 was to be transferred to a hospital and now had good motor movements on his right side. - 10/13/09 at 3:00 PM: Patient #4 was transferred to the helipad for transfer to a helicopter. The paramedic documented that Patient #4 was stable and report and copies of Patient #4's chart were given to the Lifeflight crew. - 10/13/09 at 3:15 PM: The paramedic called the secondary hospital's ED and gave a report. Patient #4's record contained no documented evidence that the CAH's ED RN had supervised the paramedic or Patient #4's care. c. Patient #9 was a 59 year-old-female who was brought to the CAH's ED on 12/11/09 via EMS. Patient #9's record contained the following nursing notes, as documented by the LPN: - 12/11/09 at 7:15 PM: Patient #9 had complained of fatigue, headache, and slurred speech. The assessment stated she had a history of hypertension and diabetes. The assessment stated she was "drowsy; confused; lethargic..." It said her pupils were contracted and non-reactive. The section of the assessment which asked for the time the physician was called and the time the physician arrived was not completed. - 12/11/09 at 7:34 PM: A report was made by telephone to the physician at 7:34 PM, and orders	C 296		

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C 296	Continued From page 18 were received for laboratory tests and a CT. - 12/11/09 at 8:08 PM: The physician was seeing Patient #9. - 12/11/09 from 8:18 PM to 8:35 PM: An RN administered intravenous medication to Patient #9 but no assessment or other care by the RN was documented. Patient #9's record contained no documented evidence that the CAH's ED RN supervised the LPN or Patient #9's care. d. Patient #10 was a 60 year-old-male who was brought to the CAH's ED on 10/15/09 via EMS. Patient #10's record contained the following nursing notes, as documented by the LPN: - 10/15/09 at 6:25 PM: The patient ambulated into the ER and the chief complaint was "MENTAL STATUS CHANGE." The assessment stated Patient #10 was disoriented. - 10/15/09 at 6:30 PM: The physician was notified of Patient #10's arrival at that time. The only person to assess Patient #10 between his arrival at 6:25 PM and the physician's examination at 7:35 PM, was an LPN as documented in the 10/15/09 nursing notes. - 10/15/09 at 10:10 PM: Patient #10 was transferred to a regional medical center via ambulance. Patient #10's record contained no nursing notes by an RN to indicate the RN supervised the LPN or Patient #10's care. On 12/21/09 starting at 11:35 AM, the CAH's	C 296		

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C 296	Continued From page 19 CNO was interviewed. She stated that an RN was scheduled in the ED 24/7. She stated that the ED RN was also the CAH's Medical Surgical Charge RN during their shift. This was confirmed with review of 11/09 and 12/09 staffing records. An RN ED/Medical Surgical Charge nurse was interviewed on 12/21/09 starting at 2:45 PM. She stated that the ED paramedics and other staff were very confident in assessing and caring for patients. She stated that she did oversee their care provided to patients, but did not document that oversight in patients' records. The hospital failed to ensure care was provided and/or supervised by an RN.	C 296		
C 336	485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that - This STANDARD is not met as evidenced by: Based on staff interview and review of patient records and PI records, it was determined the CAH failed to ensure the PI program had analyzed all patient complaints for 1 of 2 patients (Patient #11) reviewed, who had filed complaints. This resulted in the potential for the CAH's ability to develop and implement processes to improve patient relations to be impeded. The findings include: 1. The CAH's ED Patient Satisfaction Survey Report, dated from November 2008 to October 2009, was reviewed. The Nursing Staff	C 336		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2010
FORM APPROVED
OMB NO. 0938-0391

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C 336	Continued From page 20 Courteous and Friendly section of the report documented the following results: - Completely Dissatisfied: April 2009 = 4%, May 2009 = 3%. - Somewhat Dissatisfied: November 2008 = 6%, January 2009 = 15%, April 2009 = 4%, May 2009 = 3%, June 2009 = 5%. The Director of Quality Management was interviewed on 12/21/09 at 10:40 AM. She stated all employees are given a yearly in-service on costumer service. She stated if she received a complaint about an individual, she would follow up with that individual in accordance with the CAH's Complaint and Problem Identification Resolution policy. The CAH's Complaint and Problem Identification Resolution policy, dated 2002, stated that after receiving a complaint, a report of findings and action taken must be completed and given to the Director of Quality Management within seven days. However, the policy was not implemented as follows: Patient #11 was a 52-year-old female who was admitted to the CAH ED on 8/25/09 for treatment of a migraine headache. A Process Improvement/Resolution Report, dated 8/27/09, stated Patient #11 complained to the Director of Quality Management. The report stated Patient #11 said the ED nurse was a "jerk to me." The Process Improvement/Resolution Report did not include a report on findings and action taken. The CNO was interviewed on 12/21/09 at 10:40 AM. She stated that she did talk to the nurse	C 336	C 336: Unfortunately there was a miscommunication on this statement because that is not the Quality Management Director's normal process, nor is that in accordance with our policy. And I apologize if anything said misled the reviewer to believe this is our process. Employees are given a yearly customer in-service, this part of the statement is correct. Additionally, they are provided with routine customer service emails that include customer service motivational quotes that have been submitted by fellow employees. We have a customer service team which is lead by our HR Director that meets several times a year in an effort to keep our focus on delivering stellar customer service. However, if there is a complaint about an individual, that information is provided to that individual's Department Manager on our PI forms (blue sheets) who in turn is responsible for the findings and actions related to counseling/education, disciplinary steps, etc. with their staff. The Department Head then returns the form to the QM Director with written/verbal responses, from which the QM Director prepares a report that is reviewed and discussed at our monthly QI Committee meeting. That same report is available for review and discussion at Medical Staff and our Board of Directors. As was the case with patient #11. There is a similar process in our HR/Community Relations Department for negative comments noted on returned patient satisfaction surveys. This does not mean that the QM Director never discusses an incident with specific staff involved. Sometimes staff will request additional information or just feel the need to further explain in addition to what they have already discussed with their supervisor. Or QM Director may have the need for additional information from staff. But the responsibility for staff follow up does fall to the individual Department Managers, which is per our policy. In the future, WKMH will be more diligent in obtaining a completed response from the Department Managers requiring comprehensive documentation of findings and actions. Our existing PI form has been modified to enforce this. As noted on this revised form, if the QM Director has not received a response back within 7 working days from the Department Manager, the CEO will be notified. A copy of the revised PI form has been attached along with the two monthly QI reports where the incident with patient #11 was reported and a copy of our policy regarding the handling of patient complaints. 1-21-10 Gay Johnson, RN QM Director	

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C 336	Continued From page 21 about the incident. She stated that the nurse had a history of being "black and white" and felt that Patient #11 was drug seeking. She stated that the nurse was a bit short with Patient #11 and was counseled. During this interview the Director of Quality Management stated that she did not write a report of findings and actions taken with this complaint. The CAH failed to ensure that all patient complaints include a report of the findings and actions taken in order to ensure the PI program included all quality indicators, including patient complaints and reported satisfaction.	C 336		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint survey of your CAH. The investigation was conducted by Patrick Hendrickson, RN, HFS.	B 000		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C336 as it relates to the failure of the CAH to ensure the PI program had analyzed all patient complaints.	BB124		
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88) 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to,	BB297		

Bureau of Facility Standards

Max Lowe — CEO — 1-21-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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BB297	Continued From page 1 the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and (10-14-88) c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88) g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs, equipment, and supplies; and (10-14-88) i. Policy and supporting procedures involving toxicology; and (10-14-88)	BB297		

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BB297	Continued From page 2 j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88) k. Policy involving instructions relative to disclosure of patient information; and (10-14-88) l. A policy for integration of the emergency room into a disaster plan. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C274 as it relates to the facility's failure to ensure policies and procedures for emergency medical services were developed and/or implemented to meet all of emergency service requirements.	BB297		
BB298	16.03.14.370.02 Staffing 02. Staffing. There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: (10-14-88) a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed. (10-14-88) b. A qualified registered nurse shall be on duty in the facility and available to the emergency room at all times. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C201 as it relates to the failure of the CAH to ensure physicians were on-site and assessing patients' medical needs within 30 minutes. 2. Refer to C296 as it relates to the failure of the	BB298		

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BB298	Continued From page 3 facility to ensure RN had supervised and evaluated the nursing care provided by dependent staff (LPNs and paramedics) in their deliverance of patient emergency care.	BB298		